A STUDY OF PSYCHO-SOCIAL FACTORS WHICH HAVE HELPED FIFTY TUBERCULOUS PATIENTS KNOWN TO MUIRDALE SANATORIUM ACCEPT MEDICAL RECOMMENDATIONS FROM 1946 - 1952

A THESIS

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CHAPTER I

INTRODUCTION

Significance of the Study

Retaining a tuberculous individual in the hospital from his diagnosis to his recovery is one of the problems in tuberculosis control. In many parts of the country actual facilities to help this individual attain recovery are not available. In other areas the facilities are available but are not fully utilized. A large percentage of patients leave the hospital against medical advice without receiving maximum benefits, and some who stay, adjust poorly to the regimen prescribed and do not follow medical recommendations. Many studies have been made on the recalcitrant tuberculous patient and the reasons for his resistance to hospitalization and therapy. These studies deal with individuals who find adjustment to social controls difficult, and specific reasons for failure to adjust are not easily localized or measured because these individuals may have reasons to justify their reactions.

Those who are interested in helping a patient use the medical care necessary for his recovery and to accept a possible physical limitation, find the problems challenging in working with the tuberculous. The importance of this fact may be realized when hospitals in different parts of the country report that 22 to 65 per cent of their patients leave "At Own Risk."[1] A recent study by Drolet and Porter revealed that in four

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[1] Jean Berman et al, "The Signing Out of Tuberculous Patients," Tuberculosis Abstract, National Tuberculosis Association, XIX (August, 1946), 102.

hospitals of the Metropolitan New York area, one-third of the patients left against advice in 1947.[2] A study the same year by the Veterans Administration on recalcitrance among tuberculous veterans indicated that the irregular discharge rate was 54.4 per cent;[3] Dr. I. D. Bobrowitz, superintendent of the Otisville Sanatorium in New York State, estimated that from 20 to 50 per cent of patients leave against advice.[4] These persons interested in the tuberculous patient point out that reasons for irregular discharges vary, but their findings can be grouped under three broad headings, namely, inability to adjust to sanatorium regimen, home or family concern and psychological factors.

Recalcitrant tuberculous patients constitute a double menace, first, to the community because of the possiblity of spreading their infection and, secondly, to themselves because their action invariably results in the deterioration of their physical condition. Peter Dettweiler, a German scientist and authority on tuberculosis said that the successful cure of tuberculosis depended both on the character of the patient and on the pocketbook.[5]

Although many eminent physicians have stressed character in terms of the psychological aspects of the disease, much attention has been paid

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[2] G. J. Drolet and D. E. Porter, "Why Do Patients in Tuberculosis Hospitals Leave Against Advice," A Report of the New York Tuberculosis and Health Association, (New York, 1947), p. 39.

[3] Veterans Administration, Irregular Discharge, (Government Printing Office, October, 1948), p. 1.

[4] Beatrice B. Berle, "Emotional Factors and Tuberculosis," Psychosomatic Medicine, X (November-December, 1948), 369.

[5] Jules V. Coleman et al, "Psychiatric Contributions to Care of Tuberculous Patients," Journal of American Medical Association, CXXXV, (November, 1947), 699.

to economic security. In some cases it has been necessary for the public to assume financial responsibility. "One of the most important contributions ever made to the progress of the tuberculosis movement in Wisconsin was the passage of the "Free Care Law" in 1945."[6] All persons having legal settlement in Wisconsin or who have lived in the State a total of five years can have free sanatorium care. The patients at Muirdale Sanatorium, Milwaukee County, Wisconsin benefit from this free care program.

According to an authority on the subject,

> There are other diseases which, like tuberculosis, require a long term hospitalization; there are contagious disease other than tuberculosis which demand isolation and separation from family and friends and there are other diseases, as well as tuberculosis, that have no specific speedy cure. However, few of man's ills can equal tuberculosis in the degree to which it combines all these devastating characteristics, creating a personal, psychological and social burden for the individual that is too over-whelming without outside help and support.[7]

In spite of the psycho-social and environmental difficulties that predispose tuberculosis, aggravate it, or interfere with obtaining full benefits from medical care, there is a majority group of patients who do not reject therapy. They make adequate adjustment to the hospital regime and remain hospitalized until sufficiently cured to warrant discharge. It may be assumed, therefore, that although the causes of recalcitrance among tuberculous patients are ever present, there are resources within

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[6] Free Care For Wisconsin's Tuberculous: A Christmas Seal Publication (Wisconsin Anti-Tuberculosis Association).

[7] William B. Tollen, "Why Do Patients Go AWOL," Bulletin of National Tuberculosis Association, XXXVI (July, 1950), 101.

a patient who can accept medical recommendations or within the sanatorium or community, which tend to counteract the tendency to abscond. An understanding of patients and their feelings about what they are experiencing and a knowledge of the resources that are available seem essential for the medical social worker who invariably has to work with the tuberculous patient. In considering these factors, the members of the Wisconsin Anti-Tuberculosis Association expressed a desire to have a study made of the resources which attributed to the adjustment of the hospitalized tuberculous.

Purpose of the Study

The purpose of this study was to isolate and identify as far as possible, the personal, social and institutional factors which have helped tuberculous patients to accept and follow medical recommendations; to specify what situations or attenuating circumstances aggravated so-called "cooperative" patients to the extent that they considered absconding or did leave the hospital against medical advice; and to determine the psychosocial factors which enabled patients to adjust to sanatorium regime.

Method of Procedure

Fifty cases were selected by simple random sampling of those patients, whom the doctors in charge felt reasonably sure, had recovered sufficiently to warrant an early discharge. It was believed that a sampling of fifty patients, who were to be discharged shortly, would be more representative, than a group of already discharged persons who belonged to "Ex-patient Clubs,"[8] because the latter group tend to represent an ideal or more stable

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[8]The Ex-Patient Clubs in Wisconsin or "Come-Back-Clubs," made up of ex-tuberculous patients. Objectives are education, recreation, rehabilitation employment of the tuberculous and encouragement to others.

group. Personal interviews were conducted with patients and data selected according to an interview schedule. Conferences were held with sanatorium personnel and personnel of the Wisconsin Anti-Tuberculosis Association, who had a technical knowledge of tuberculosis and this type of study. The writer also read available case records by means of a schedule and pertinent literature.

Scope and Limitations

The study was confined to fifty tuberculous patients known to have been hospitalized at Muirdale Sanatorium in Milwaukee County, Wisconsin from 1946 to 1952, however, only forty-three of the patients were interviewed. Six patients of the remaining seven were discharged before they were interviewed, and one, was unwilling to be interviewed. The information obtained in the study pertaining to these seven patients was, therefore, limited to their case records.

The patients used in this study were not typical of those in any sanatorium governed by the Free Care Law of Wisconsin, but typical of Muirdale Sanatorium, the largest in the State serving exclusively a metropolitan urban area with a considerable Negro population and other groups characteristics of large cities, but not of other areas in Wisconsin somewhat rural in composition.

CHAPTER II

FACTORS AFFECTING ACCEPTANCE OF MEDICAL RECOMMENDATIONS

Isolation and treatment of patients with clinical disease constitute important factors in the control of tuberculosis. Many patients prefer to remain at home under the care of private physicians or clinics. This procedure may be justified if sputum can be kept negative for tubercle bacille or if adequate measures can be taken for the protection of persons with whom they come in contact.[1] For the majority of tuberculous patients, however, hospitalization is advised.

Patients' reactions to the recommendations for institutional care are as varied as the life forces that shape them, because individuals entering a hospital bring with them the sum total of their life experiences. Disease itself does not produce a new personality. It can only act upon the soil prepared for it; it can only influence inherent characteristics.[2] There are personal factors which affect the patient's ability to accept medical recommendations; the family from which he comes and the environment in which he lives frequently determine, to a considerable degree, what kind of patient he is, and whether he will make the most or the least out of his hospital experience. The institution itself and what it affords in the way of therapy and program content may induce or inhibit the patient's acceptance of hospitalization. Understanding the

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[1] Herman Epstein and H. W. Hetherington, "Problems in the Treatment of Advanced Tuberculosis in a Municipal Hospital," Journal of American Medical Association, CXIV (March 2, 1940), 723.

[2] Ben Wolepor, "The Mind and Tuberculosis," American Review of Tuberculosis, XIV (March, 1929), 314.

patient's background may supply the explanation for a patient's attitude toward his disease and its treatment and may provide a key to his cooperation in accepting medical recommendations for treatment.

Institutional Features

A modern, well-equipped sanatorium is the best place for the patient with tuberculosis. In such hospitals, the constant supervision by doctors and nurses thoroughly trained in caring for tuberculous patients insures that the patient will have the greatest chance of a satisfactory recovery and facilitates the fullest possible return to his earning capacity and usefulness as a citizen. It also means that the patient learns how to take care of himself so as to prevent further breakdown, while it removes him from the family and associates until he no longer can spread his infectious disease.

Muirdale Sanatorium,[3] a medical institution, was established for the purpose of providing medical care for the tuberculous patient, to train him in hygiene and sanatation and to restore him to his working capacity. Its proximity to the city which it serves facilitated the visiting of family and friends.

The sanatorium afforded a normal capacity of 621 beds. Approximately two-thirds of the beds were for males and children and one-third for females. These beds were located in the hospital building proper and in outlying cottages. Criteria for the hospital ward or cottage residency was based on exercise classification.[4] This plan served as one of the means of

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[3] Largest sanatorium in Wisconsin, located in Milwaukee County on Highway 100, six miles west of Milwaukee.

[4] Period of graduated exercise, one through ten, by which patients' response to activity is evaluated.

segregating the "acutely ill" from the "less ill" and ambulatory patients.

Medical standards in the sanatorium were maintained at a high level. The resident staff at the time of this study provided for a full-time medical director, chief senior physician, assistant senior physician and eight staff physicians. Psychiatric consultation was available but was primarily for the purposes of diagnosis and disposition rather than for treatment of patients remaining in the sanatorium. Other medical provisions were for visiting surgeons, roentgenologists, anesthetists and a part-time dentist. Consultative services in various specialties, such as eye, ear, nose and throat were also provided for the patient.

The nursing division consisted of one superintendent of nurses, twenty-five graduate nurses, approximately ten trained practical nurses and 158 hospital attendants. In connection with the medical and nursing care available, the minimal standards of the American Trudeau Society were as follows:

> There shall be in addition to the Medical Superintendent, at least one full-time resident physician for the first 100 patients, and one additional full-time physician for each additional patients or the major fraction thereof....the services of consultants in internal medicine, general surgery and in the medical and surgical specialties should be utilized.[5]

The minimal standards for nursing service as prescribed by the American Trudeau Society were as follows:

> Nursing service shall be properly adjusted with respect to the proportion of infirmary, semi-ambulant and ambulant patients, the ratio of nurses for whom shall be not less than 1:3, 1:8 and 1:30 respectively. This is for twenty-four hour coverage....In calculating the ratio of nurses to patients, suitable credit may

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[5]Ralph Horton, "Report of the Committee on Sanatorium Standards of the American Trudeau Society," American Review of Tuberculosis, LI (May, 1945), 482.

> be given for services performed by orderlies, nursing attendants or other well-trained auxiliary workers.[6]

According to the minimal medical standards prescribed by the American Trudeau Society, both medical and nursing staffs appeared to be adequate at Muirdale Sanatorium. Under the supervision of the medical and nursing personnel was an active program of various forms of collapse therapy, including surgery and chemotherapy.

In addition to these services, the social service department consisted of five full-time persons specially trained in the medical-social aspects of tuberculosis. These social workers gave help, not only with the "practical problems" which are coincidental with illness, but also with the emotional factors which may contribute to illness and which frequently influenced the patients' ability to benefit from medical care.

Occupational Therapy was provided for the patient to alleviate monotony, which usually accompanied long time hospitalization. It provided for mental and physical activity aimed to hasten his recovery from disease and to assist in a patient's adjustment to hospital regimen.

Other institutional features at Muirdale Sanatorium were Vocational Rehabilitation, visits from clergymen and weekly church services, a postal station, radio system, occasional movies, recreational activities for those so classified, a school room for cultural growth, and a lending library.

Personal Aspects

The fifty patients, who were hospitalized at Muirdale Sanatorium at the time of this study, represented a heterogeneous nationality group, although only one member was foreign born. The fact that these patients

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[6] Ibid., p. 485.

accepted hospitalization did not indicate that they accepted their diagnosis passively. Approximately four-fifths of the group were diagnosed as having moderately or far advanced tuberculosis and in the main, upon being informed, experienced mental shock or complete bewilderment. Those few, who did not react in this manner, gave as their reasons some familial tuberculosis, or at the time of diagnosis, their age prevented an understanding of the diagnosis and what treatment entailed.

Of the shocked reactions, three out of the four Negroes included in the study attributed their emotional disturbance to the stigma attached to the disease by lay groups. When asked how they felt about being hospitalized for a long period of time, three-fifths of the study group stated it was difficult to accept; two-fifths were able to accept long term hospitalzation for diverse reasons; and the most prevalent answer was some education on the nature and treatment of tuberculosis. Next in prevalence was previous hospitalization for tuberculosis. Only one patient said that he was "too sick to care." Table 1 shows some personal factors which may have affected the response to medical suggestions for hospitalization.

The so called "cooperative" group that anticipated early discharge consisted of thirty-five females and fourteen males. The preponderance of females and the age distribution followed that of the characteristic tuberculosis mortality curve which shows a peak in female in early adult life.[7] Over three-fifths of the fifty patients studied were under thirty-four years with a median age of twenty-nine. They represented a

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[7] Harold Holand et al, Report of Committee on Unhospitalized Sputum-Positive Cases, Wisconsin Sanatorium Superintendents' Association (Milwaukee, Wisconsin, April 6, 1946), p. 5.

TABLE 1

SEX AND AGE

	Age	Total	S E X Male	Female
Total		50	14	36
	Under 20	4	2	2
	20-24	8	2	6
	25-29	12	-	12
	30-34	10	1	9
	35-39	5	3	2
	40-44	4	3	1
	45-49	2	-	2
	50-54	2	2	-
	55 59	1	-	1
	60-65	1	1	-
	Over 65	1	-	1

morbity group rather than a mortality incidence which suggested the receptability of young people to advice from persons in authority who recommended their hospitalization and retention until their condition warranted discharge.

Table 2 shows that one-half of the persons studied were Catholic and the remaining one-half Non-Catholic who were represented by diverse Protestant faiths including two Christian Scientists and one of Hebrew faith.

TABLE 2

MARITAL STATUS AND RELIGION

Marital Status	Total	RELIGION	
		Catholics	Non-Catholics
Total	50	25	25
Single	24	11	13
Married	19	8	11
Divorced	3	3	-
Separated	1	-	1
Widowed	3	3	-

The greatest concentration was seen in the Catholic group in this study of "cooperative patients" and indicated the likelihood of accepting authority because of the nature of their religious belief. There was a greater number of single and separated patients, about three-fifths, than married ones which suggested that it was easier for the single and unattached person to accept hospitalization than those who had to plan in connection with a family or spouse.

Table 3 shows that only about one-fifth of the study group were unskilled. The remaining patients, approximately four-fifths, who included the skilled, professional and unemployed, appeared to have been in a position not to have undue concern over employment or the possibility of re-employment after recovery. This was further accentuated by the fact that this majority group had some degree of education above grade school level. Their educational attainment may also have attributed to

TABLE 3

EDUCATION AND EMPLOYMENT

Educational Level	EMPLOYMENT				
	Total	Skilled	Non-Skilled	Profes-sional	Not on Labor Market*
Total	50	17	11	5	17
Less than Grade School Completed	3	1	-	-	2
Grade School Completed	3	1	2	-	-
Partial High School	18	7	4	1	6
High School Completed	20	7	5	1	7
One Year College or More	5	-	-	3	2
Some Business or Professional Training	1	1	-	-	-

*Classification "not on labor market" included invididuals who were students, housewives or physically unemployables at time of hospitalization.

their own ability to understand the interpretation of their diagnosis and recommended treatment plans. It is worthy of note that almost one-half of the majority group were not financial contributors to the family income. This situation may have been an inducing factor toward their accepting hospitalization.

Environmental Conditions

Table 4 points out that almost one-half of the group were living with family members and therefore were relieved of housing responsibility at the time of their hospitalization. In addition, this majority group was under no apparent financial strain. Only one patient was without some type of financial support after hospitalization. Only four patients

TABLE 4

HOUSING AND SOURCE OF FINANCIAL SUPPORT

Housing*	Total	SOURCE OF SUPPORT* Spouse	Parents	Other Fam. Members	Private Income	Public Asst.	None
Total	50	17	14	7	8	1	3
Home Owner	8	5	-	-	3	-	-
House Renter	5	3	-	1	-	1	-
Apartment	9	6	-	1	1	-	1
Room	6	3	-	1	1	-	1
With Family	21	-	14	3	3	-	1
Other**	1	-	-	1	-	-	-

*Refers to type of housing patient inhabited at time of hospitalization and source of support during hospitalization. This source supplied patient's needs if there were any.

**Refers to any type of housing outside family where there was not any responsibility for payment of rent.

out of the fifty studied did not have any source of financial aid and had to accept assistance to meet financial needs for themselves and/or their family. It appeared, that the overwhelming majority then, could accept

hospitalization without worry over economic obligations or the financial upkeep of homes.

Table 5 shows that forty-three patients of the group had one or both natural parents living when they resided in the family setting; and thirty of this majority had both parents. Four-fifths of the total group came from families with at least two siblings and three or more brothers and sisters. The majority of the patients were exposed to parental influence and were not from broken homes, had some predisposition to familial security and some previous experience in group living and adjustment in a family setting. These factors did have bearing upon their response to hospitalization which required a measure of social control and group adjustment.

TABLE 5

MARITAL STATUS OF PARENTS AND NUMBER OF SIBLINGS

Marital Status of Parents When Patient Lived in the Home	NUMBER OF SIBLINGS				
	Total	None	One	Two	Three or More
Total	50	6	4	12	28
Living Together	30	2	1	9	18
Divorced	1	-	1	-	-
Separated	1	-	-	-	1
One Parent Dead or Unknown	13	2	2	2	7
Both Parents Dead or Unknown	4	1	-	1	2
Not Indicated in Record	1	1	-	-	-

In considering the factors which influenced the acceptance of hospitalization of these fifty patients at Muirdale Sanatorium, the hospital program was well rounded; and the setting was conducive to treatment and the recovery of a patient who was hospitalized. The patients studied were predominately young adults who were receptive to advice and authority. They came from family settings which operated as a springboard for hospitalization and facilitated their taking advantage of what the hospital afforded. This was accentuated by the fact that the majority were single and unattached and did not have the added conflict that accompanies the disruption of families or homes. In addition, most of the group seemed to have sufficient economic means and were not hampered by financial worry which perhaps minimized any anxiety centered around planning personally or for their families.

CHAPTER III

SITUATIONS WHICH CAUSED PATIENT TO CONSIDER ABSCONDING

The tuberculous patient who accepts medical recommendations for hospitalization, for the most part, enters the hospital with an avowed purpose of remaining until he has regained his health. However, when he accepts hospitalization, he does not leave his anxieties and tensions behind him. These emotions accompany the prescribed long term rest regime which has become a basic technique in treatment of tuberculosis and necessitates months or years of restricted activity. This prolonged rest period also involves a negation of one of the most elemental tendencies of human nature; the tendency to seek release of emotional and psychic energy when the personality is supercharged with feeling.[1]

The complex life in a hospital also presents the problem of adjustment to companions, doctors, nurses and other personnel. The patient attempts to make this adjustment, while in some instances, environmental circumstances are not conducive to his being able to concentrate wholly on the task of regaining his health. He cannot relax physically, emotionally or mentally, which is a concomitant part of his treatment.

Contributing Factors

In addition to the anxieties and tensions which the patient brings with him to the sanatorium and which plague him for want of release, coupled with his hospital adjustment and environmental problems, the tuberculous patient is confronted with new anxieties. These anxieties

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[1] Veterans Administration, op. cit., p. 6.

may center around the fear of surgery or an even greater fear of death because of slowness in recovery. It is no small wonder that many tuberculous patients do not always manifest the rationalism necessary for their recovery. Many patients consider absconding, and still others actually leave the hospital against their better judgment and against medical advice.

The fifty patients studied were no exception; twenty-three of them considered absconding and twelve left the hospital at one time against advice; fifteen verbalized no intense grievances about their hospital life which would precipitate their recalcitrance. The redeeming feature about the majority group was that the twenty-three, who considered interrupting their treatment, reconsidered and remained; and the twelve, who left, returned and continued treatment until sufficiently recovered to warrant an early discharge.

The average length of stay in the sanatorium for the total study group was fifteen months to two years. There was only one patient whose stay was under six months, and only two, whose stay exceeded three years. Forty-four patients out of the total group underwent major surgery.[2] An overwhelming majority accepted surgery which fact indicated that these patients realized that the sanatorium afforded treatment measures that could not be obtained at home.

The factors or situations which aggravated patients to the extent that they considered absconding or did abscond are listed according to

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[2] Refers to "thoracoplasty" or "resection." The former is an operation or form of collapse therapy wherein ribs are removed over diseased area of the lung. The latter involves removal of one segment of lung or small wedges of lung tissue.

degree of prevalence in Table 6 under the broad headings of institutional, environmental and personal factors. All patients expressed recurrent melancholia as an aggravating factor, but felt that it was a natural occurrence in view of long term hospitalization.

TABLE 6

FACTORS AGGRAVATING PATIENTS TOWARD ABSCONDING, AND ACTUALLY PRECIPITATING ABSCONDING

Factors	Total	PATIENTS	
		Absconding Considered But Not Carried Out	Absconding Carried Out
Total	35	23	12
Institutional			
Problem Related to Surgery	11	8	3
Problem with Hospital Attendants	5	5	-
Problem with Roommates	4	4	-
Desire for Outside Medical Consultation	3	-	3
Environmental			
Worry Over Care of Children	3	2	1
Home Problems	2	-	2
Marital Problems	1	1	1
Desire to See Child	1	-	1
Personal			
Despondency Over Slow Progress	5	3	2

Over half of the thirty-five patients were aggravated because of institutional factors; environmental factors prevailed secondly; and least of all in prevalence were those factors considered as personal. It appears, therefore, that the majority of these irksome factors or situations were modifiable. In consideration of the factors which influenced absconding, it is commonly believed that often it is not one reason which caused the patient to leave the sanatorium against medical advice, but a multiplicity of grievances.

The fact that no patient gave as reasons for absconding problems related to attendants, roommates and marital troubles, indicated that although provoking, these problems were not so intense that the patient could not work out at least a feasible solution. There was a differnce in the number of patients who were embittered by problems related to surgery, despondency over slow progress, and care of children and the number that actually left against medical advice because of these type conflicts. Obviously, the majority of this group who cited those factors as agitating, were able to re-evaluate their decision to abscond.

The total number of patients who considered absconding because of home problems, or because of a desire to see children and a desire for outside medical consultation, did leave because of these pressing needs. It appears, then, that these situations were of such a nature that the patients felt they could be handled only by him on the "outside." Complaints about food were not cited as major grievances; and no patient who absconded gave as a reason, "inability to adjust to hospital regime," which was a factor found in most studies of irregular discharge. In considering the latter, the patients in this study adapted with ease to

social control.

Analysis of Agitating Factors

The basic causes which prompted thirty-five patients in the group studied to consider absconding or which attributed to the recalcitrance of twelve, and a description of the reasons was as follows: In considering the institutional aspects and the problems related to surgery, only one patient acknowledged fear of surgery, but this patient did not abscond. The majority of patients who accepted surgery in the total study group attested to desiring surgery, rather than fearing it. They felt that surgery was the "only way out." Therefore, the problems related to surgery were of a different nature.

Ten of the patients, who cited surgery as a real problem, gave as their reasons misunderstanding of treatment plans or lack of their preparedness for surgery by medical personnel. A case in point was that of a young woman, who had undergone a thoracoplasty. She was informed by medical personnel that after a necessary convalescent period and continued negative sputum and aspirates, she would be considered for discharge. At the cessation of many months of convalescence, the patient was recommended for more surgery, rather than discharge. According to her, "this was a shock as I was totally unprepared mentally to accept additional surgery, especially when my mind was set on going home. If they had just told me before time for the operation, maybe I would have been used to the idea. I knew that more surgery would mean many more months of convalescence afterwards and I just couldn't take it." The patient left the hospital against medical advice.

Another woman gave as the reason for leaving that she was not able

to understand why patients were classified differently when they all had tuberculosis. She complained of not having had clarification as to her condition because the doctors used "too many large words" beyond her limited understanding of medical terminology. Still another patient anxiously awaited surgery, only to be told that there had been a mistake in the scheduled time. This patient resented having been "led on" and was disappointed when the time came for the expected surgery.

Five patients mentioned difficulties with hospital attendants. Although this grievance did not cause any patient to leave against medical advice, the patients said that the "inconsideration" of attendants was most provoking. One woman patient claimed that the attendants had spread malicious gossip over the hospital about her. Another male patient became aggravated with attendants because they repeatedly misplaced some of his personal belongings in the process of cleaning. A woman patient resented being told by attendants to "pick up your own garbage" and to refrain from using the "bed pan." She felt, too, that the attendants treated the patients like a "bunch of numbers."

Only four patients out of the fifty patients studied voiced discontent with roommates. Two of these patients expressed a dislike for living arrangements with more than two roommates because of personality conflicts. At the time these patients were interviewed, they were sharing a double room. However, at one time during hospitalization, they were faced with the problem of adjusting to as many as five other persons in one room. Though neither of the two patients absconded because of this problem, they considered it an annoyance.

Another patient described his roommate as a "bully", who pestered

him and "got on his nerves." One other patient became very "upset" because he was placed in a room with a very ill patient who "moaned" during the day and night. This patient stated that the constant disturbance interfered with his mental and physical relaxation.

Only three patients expressed dissatisfaction with medical treatment and desired outside medical consultation. Two of these patients left the hospital against medical advice because they claimed illness other than tuberculosis and felt that the doctors were only interested in their tuberculous condition. One of the two patients claimed that the doctors had stated that she was malingering when she was "really sick" as a result of other physical complaints. On the other hand, only one patient sought outside medical consultation for his tuberculous condition. He felt that he was "confused" most of the time because various doctors interpreted his condition to him differently and that the doctors were uncertain of the treatment required; this proved detrimental to his recovery.

Worry over the care of children was mentioned by only three patients and could be considered an environmental factor effecting recalcitrance. In families where the temporary dissolution of the home arose from the absence of one parent, complaints that children were not being cared for properly resulted in a patient leaving the hospital. Two patients expressed worry of this type which almost attributed to the recalcitrance of one and did cause one patient to leave the hospital against medical advice in order to reassure herself that her children were being cared for properly.

Two patients expressed discontent while hospitalized because of

problems within the home. Another patient worried over the financial struggle in which his wife was engaged since his hospitalization. Although aggravated, the patient remained hospitalized. One other patient left the sanatorium during her treatment period because she feared that her daughter and aged mother were going to be evicted. She felt that only she could "straighten this matter" with the landlord.

One patient professed marital difficulty as a threat to her hospitalization. This patient accused her husband of neglect and infidelity and many times considered leaving the sanatorium in an effort to strengthen her marital relationship. Another female patient gave as her reason for absconding, the desire to see her baby, who was born while she was hospitalized for tuberculosis. The baby was immediately taken from this mother as a precautionary measure. After six months of not having seen her child and worrying as to whether it was disfigured, this mother "couldn't stand it any longer" and left against medical advice.

Despondency over slow progress had some influence upon five patients who stated that what aggravated them most was the inability to see further improvement which caused despondency and a desire to "give up" and leave the hospital. Many tuberculous patients reach a somewhat stationary point in treatment where it is deemed wise not to increase their physical acitivity for a time. This frequently occurs when they are really feeling their best, and the prospect of a modified rest regime of possible months duration overwhelms them. Such patients tend to give up attempts at further disciplined treatment, and depart for home to try to get along as best they can on a limited activity sched-

ule.[3] Two patients absconded because of their despondency and apparent slow progress.

It is evident that tuberculosis is a medical and psychological problem. Its treatment requires a healthy mind as well as a good physical constitution. Although the patients studied entered the sanatorium with the hope of regaining their health, disturbing forces from a personal and environmental standpoint interfered with their hospitalization. Some patients were able to withstand these pressures and make an adjustment to the reality of the situation; others used protective mechanisms whereby they fought against reality and escaped. There did not seem to be any constant point at which patients studied felt that the hospital was no longer bearable, nor did there seem to be any constant factor among the group studied at Muirdale Sanatorium which precipitated recalcitrance. It was an individual problem, depending largely on the personality pattern of the patient, the extent of the pressure in the situation and his capacity to make an adjustment.

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[3] L. G. Galisnsky and S. Brownstone, "The Fate of the Sanatorium Patient: A Study of Patients Discharged from Iowa State Sanatorium During 1937 and 1938," Diseases of the Chest, V (December, 1939), 14.

CHAPTER IV

EMOTIONAL AND SOCIAL FACTORS AFFECTING PATIENT'S ADJUSTMENT

The aspects of sanatorium living impinge in varying ways upon the patient, and influenced by his needs and feelings of the moment, he will accept them as opportunities or resent them as arbitrary, unauthoritative restrictions.[1] In short, the patient may use the hospital experience positively or negatively. Dr. William Osler, an outstanding authority on tuberculosis has stressed the importance of knowing what is in the patient's head as well as what is in his chest, if you want to predict the outcome of his pulmonary tuberculosis.[2]

The factors which influenced the adjustment of the fifty patients included in this study indicated that their attitudes played an important part not only upon their acceptance of treatment, but also on their ability to adapt to long term hospitalization. Although the majority of the patients in the study group expressed a more than "hopeful" attitude regarding their chances of recovery, their adjustment could not be related altogether to this optimistic prospective.

Additional factors which attributed to adjustment pointed out that the patient's emotional reactions to illness and hospitalization, his insecurity and his relationships contributed to the type of adjustment he made. Consequently, it cannot be assumed that all adjustment was "healthy" or "satisfactory" when the patient was considered as a person aside from his

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[1] Pauline Miller, "Medical Social Service in a Tuberculosis Sanatorium," Public Health Reports, LXVI (August 3, 1951), 988.

[2] Jerome Hartz, "Human Relationships," Ibid., LXV (October 6, 1950), 1292.

disease. Every situation in life offered its opportunity for mature or immature responses.[3] Hospitalization was a circumstance which evoked positive or negative reactions, but how the patient handled these responses was an indication of the degree of his maturity.

Emotional Maturity

The emotional reactions of the patients studied are important in the treatment of their disease in which their cooperation was essential. This was especially true in the treatment of the tuberculous patients who were hospitalized and living within regulations. They had to accept the restrictions that were inevitable in an institutional setting, and to live within the limits of energy in keeping with their physical stamina. Success of their treatment depended more upon how these patients responded to this new "education", than upon the severity of their illness.

Although it was difficult for most of the patients in the study group to accept hospitalization and, for the most part, they were confronted with aggravating situations during hospitalization, the majority of them accepted and followed medical recommendations. They remained hospitalized in spite of the many disturbing forces; they were able to recover and use the months of sanatorium life as an opportunity to reorganize their energies for a constructive post hospital career. It appeared that the majority group had internal strengths and a firm sense of reality which fostered their adjustment.

The emotional responses of a patient to tuberculosis do not begin when he enters a sanatorium or even when he is first told of the diag-

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[3] H. A. Overstreet, The Mature Mind (New York, 1949), p. 276.

nosis.[4] These reactions begin far back in childhood and are tied up with his reactions toward other sudden and shocking experiences. H. A. Overstreet, the psychologist, states that growth begins at home and that large families have an important bearing upon the problem of maturity.

> One way in which children have traditionally turned their feeling of helplessness into a feeling of strength has been through the group solidarity of the young.... though adults have been in command, the sharing of secrets among the sibling group, the working off of their hard feelings towards their parents by talking together and planning small revenges, has established a kind of community in childhood.... the larger the number of children in a home, the more effective the community of children is likely to be. Although there will be internal feuds among the community, each child is likely to have someone to be with him in time of need.[5]

The family constellation of the fifty patients studied indicated that the majority had at least two brothers or sisters, or three or four siblings as shown in Table 5.[6] In keeping with Dr. Overstreet's hypothesis, these patients came from family settings which not only fostered adjustment, but encouraged emotional maturity.

In considering other factors which enabled the study group to adjust, over half of the patients gave as most significant to adjustment, their own determination to get well in spite of agitations and length of time involved. One woman patient upon admission was reported to have said, "I've made up my mind to like it here and want to do all I can to get well." Another patient when interviewed said, "I've tried to keep an optimistic viewpoint for I know that life nowhere is rosy all the time."

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[4] Jerome Hartz, op. cit.,

[5] H. A. Overstreet, op. cit., p. 236.

[6] See Chapter II, p. 15.

Another patient revealed that she voiced upon admission that her basic interest was to learn more about her disease and how to cure it. She did not believe that she would have any trouble adjusting to hospital life, and she had been "pretty well on her own" for a number of years.

There were other patients who experienced some difficulty during the adjustment process as evidenced by their recalcitrance. They left the hospital, only to return and remained until sufficiently recovered to warrant early discharge. Their resumption of treatment indicated a mature viewpoint and an acceptance of the reality of their situation. One patient gave as her reason for returning, a realization that "checking out" would not solve anything. She regretted her adverse actions the moment she arrived home because she knew that home life was not conducive to her recovery. In addition, her knowledge of tuberculosis prevented her from exposing her children and husband to the disease. She stressed a determination to remain hospitalized until properly discharged.

Another such patient stated that he had "weighed" the advantages and disadvantages of hospitalization and had concluded that santorium care was best "all the way around." He added, "As much as I want to be home with wife and children, I know, too, that I can be a better husband and father when I have fully recovered. If others can lick 'T.B.', I can too." Still another patient thought about absconding but decided to change her way of thinking. She resolved to keep herself busy, to stop discussing the "bad" side of hospital life and to refrain from "self pity." Her change of attitude sustained her through the many months of hospitalization.

Dependency Reactions

The patient's adjustment to hospitalization can be attributed to his

emotional immaturity as well as to his emotional maturity. Consciously or unconsciously, many patients react favorably to hospitalization because, whatever its disadvantages, it re-establishes a childhood situation of interest,care and dependence. It is a haven of escape from the burden of complex life, which demands so much energy, initiative, independence, responsibility and social productivity.[7]

The patient who adjusts to hospitalization because of his dependency, need not be looked upon as "unique" or an "oddity" for all individuals have dependent, regressive tendencies to some degree. They vary in different persons as to strength, importance, the degree to which they are indulged or repressed, and the balance with which they develop maturity.[8] In short, no one matures completely. "Scratch an adult and you find a child."[9]

Although it was indicated that the majority of the patients came from large families which were conducive to emotional growth, there were circumstances in the lives of a few which fostered dependency and their desire for the protection of the hospital. Three patients freely admitted that hospital life was pleasurable. One male patient said, "I like leisure time and an opportunity to "take it easy." I'll be here until I get well." This patient was from a large family, but explained that he was the oldest child and had assumed responsibility for the care of his widowed mother and siblings at an early age. Consequently, his education was interrupted at a grade school level. He was forced to accept a janitorial job and

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[7] Leon Saul, Emotional Maturity (Philadelphia, 1947), p. 34.

[8] Ibid., p. 44.

[9] Ibid., p. 33.

other "odd" jobs in order to provide some measure of economic security for his family. He continued that his brothers were maintaining the home while he was hospitalized and that he was "just plain tired."

Another patient, a woman, said that she was "glad to have a place to stay where she did not have to pay." She had never experienced any unpleasantness while hospitalized and had not entertained the idea of absconding because she did not have any place to go if she did." Still another aged woman, who was economically secure, expressed a desire for hospital life over and against life on the "outside." She enjoyed the pleasant surroundings, kept busy and had formed friendships which contributed to her happiness. Although she accepted hospitalization in a mature fashion, she seemed to have a regressive attitude toward leaving.

On the other hand, there was the passive type of individual who yielded, did not verbalize his like for the hospital, nor did he offer complaints. A case in point was that of a woman who stated that she had experienced no unpleasantness during hospitalization, had no difficulty in accepting long term treatment or surgery, and could relate no disturbing environmental factors. This patient had three small children who were being cared for by her mother in another city, was separated from her husband and had no means of support after discharge until she became self supporting. Obviously, she was using her invalidism to isolate herself from reality from which she wished to escape.[10] It is believed that these submissive persons who appeared well adjusted to prolonged hospitalization, because of a conscious or deep-seated desire to

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[10] Bertha Capen Reynolds, Social Work and Social Living (New York, 1951), p. 127.

evade the outside world, were more in need of psychotherapy than the aggressive, restless individuals, who were able to verbalize just how they felt and what they thought.[11]

There were two other patients who presented a different kind of dependency. They both cited provoking situations which contributed to their dislike for hospital life, but acknowledged intense apprehension about leaving the sanatorium and resuming a normal life. Neither patient had undergone surgery, which most patients considered the quickest "way out."

The first of these patients was a young man who had been hospitalized for a number of years and had matured chronologically in the sanatorium. He had been orphaned at an early age and had no source of income except that derived from his own resourcefulness while hospitalized. He emphasized his fondness for one of the nurses, whom he stated had "mothered" him. The patient's life experiences seemed to foster dependency elements because as a child, he was desrived of emotional and economic security. The other patient, a young woman, refused surgery. Although she had been a skilled worker prior to her illness and had some secondary education which enabled her to look forward to re-employment with little or no difficulty, she voiced great concern over the time when she would be released.

Both patients showed much ambivalence in their reactions to sanatorium life. According to Saul, this counter-action is a natural personality pattern. He further stated that "no personality is homogeneous and perfectly

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[11] George E. Daniels and Eugene Davidoff, "Mental Aspects of Tuberculosis," American Review of Tuberculosis, LVII (November, 1950), 536.

integrated. On the contrary, it is composed of many opposing factors."[12] Therefore, it was possible that these two patients showed reaction formation and objected strenuously to hospitalization, while at the same time, accepted and even desired it. An appreciation of, and watchfulness for such counter-currents are indispensable to the mental and emotional life of the tuberculous.[13]

Components of Relationship

Whether mature or totally dependent, individuals generally rely on their relationships with others to give them the psychological and social support which life in a hospital demands. This socialization is indispensable in the adjustment process of the tuberculous, whose treatment requires isolation from family, friends and community life. The patients studied did not relinquish their former relationships altogether, these were important, but they continued to add new people to those they cared about and to discover new bases of fellowship in the hospital community. The degree to which they emerged from egocentricity to sociocentricity was a determinant in the healthy adjustment of the sanatorium patient.

Although the adult patient required less emotional support than the child, yet no adult fully outgrew these needs. It was only a matter of degree, a shift in the balance of the emotional metabolism....to receive love and emotional support remained a deep need and a deep gratification.[14] The attitude of the patient's family concerning his diagnosis did have

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[12] Leon Saul, op. cit., p. 36.

[13] Ibid.

[14] Ibid., p. 31.

definite bearing on their relationship with him during his hospitalization; this relationship promoted or hindered his progress.

Forty-eight of the patients studied at Muiradle Sanatorium felt that their families were accepting of their diagnoses and were understanding of treatment measures. No patient had been harrassed by family members to resort to "home cure"; and the majority attested to having a closer relationship with family members since their hospitalization. One woman patient said, "My husband is more sympathetic now and dearer than ever before." Many patients attributed a degree of their adjustment to the thoughtfulness and kindness of relatives through the media of visits and emotional or social support. A few patients who considered absconding stated that they remained hospitalized because of encouragement from spouses and other family members who gave them the psychological support needed during this crisis.

The friendships among patients took on a special meaning for the hospitalized tuberculous patient. Many months and sometimes years of close association fostered a bond that was often-times unbreakable. Nine of the patients studied gave "counsel from friends" as a contributing factor to their adjustment. One patient stated, "My friends have helped me no end. Here, I can cry and know that someone understands." Another said, "Many times I've been despondent and felt like giving up, but after talking with my friends, who helped me to realize that I was not alone in my despondency, I was able to pull out of it." Another patient, a young man, modestly related that his fondness for one of the female patients and their courtship helped him to "get over the hump."

The relationship of patients to the medical staff was of vital importance

to their recovery and adjustment. This was especially true when the patient was considered as a person in need of psychological understanding.[15] The patient's confidence in the doctor who sincerely recognized his total interests was a "bulwark" in the treatment of the patients in the study group. Forty-eight patients verbalized having had a favorable relationship with the doctors at Muirdale which enabled them to understand their diagnoses and treatment plans and gave them the emotional support needed in times of distress and despondency. Nine patients considered their repeated consultations with the doctors as the factor which prevented their recalcitrance.

The attitude of the nursing staff and their relationships with patients was also a factor to be considered in the patient's adjustment process. The nurses shared a great portion of responsibility in the daily life of the sanatorium patient and assisted in preventing low patient morale. An overwhelming majority of the patients studied said that they had had a favorable contact with the nursing staff throughout their hospitalization.

Moreover, the social service department was primarily interested in giving the patient emotional and social support while he was attempting to complete his "cure." Every patient in the study group was familiar with social service at Muirdale as a result of initial admission. However, less than half had contacted this department for their assistance in alleviating problems with which they were confronted. This can be attributed to the fact the majority of patients studied were not beset with problems of a social nature. Those who were disturbed emotionally seemed to rely on

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[15] Gordon Hamilton, The Theory and Practice of Social Casework (New York, 1951), p. 294.

their own internal strengths and the counsel of friends and medical staff in an effort to cope with the situation. Only three patients expressed dissatisfactory results even after contacting social service, but explained that this discontent intimated no reflection on the social worker or the department, but stemmed from the nature of the problem. The concensus of these patients was "It was something that I had to work out for myself." Nineteen patients who had taken advantage of the social service program, expressed satisfaction with the results and felt that this service contributed greatly to their adjustment.

CHAPTER V

SUMMARY AND CONCLUSIONS

One of the problems in tuberculosis control is the means of retaining the tuberculous patient in hospital until he has recovered; and is difficult because the psycho-social factors which accompany long term hospitalization often-times interfere with the treatment of the tuberculous. A study of tuberculosis hospitals in the Metropolitan New York area by Drs. Drolet and Porter indicated that one third of the patients absconded in 1947. Additional studies made of recalcitrance among tuberculous patients by the Veterans Administration and Dr. I. D. Brobrowitz, point out that recalcitrance is most frequent among the hospitalized tuberculous. It has been estimated that 22 to 65 per cent of patients in different parts of the country leave hospitals against medical advice.

It had been recognized that economic insecurity is one of the great hindrances to a patient's adjustment to long term hospitalization, which is demanded in treatment for tuberculosis. An outgrowth of this awareness has led public participation in assisting financially in the treatment of tuberculosis by means of the "Free Care Law". This law is in effect in the State of Wisconsin and has contributed greatly to the tuberculosis control movement in this State.

In spite of the many difficulties which enter into the successful treatment of the tuberculous patient, economic or otherwise, the majority of patients remain hospitalized until sufficiently recovered to warrant discharge.

The fact seems to be established that tuberculosis is an emotional, social and physical disease. The personality pattern of the patients studied, the extent of the aggravating factors plus the patients' capacity to adjust in spite of these pressures, were determinants in their ability to remain hospitalized without absconding.

On the basis of the factors considered in this study, the following conclusions were drawn:

First, racial factors were of no significance to this study of tuberculous patients because they represented a heterogenous nationality group. However, almost complete homogeneity was recognized in the group with reference to the shocking effect their diagnosis had upon them and their initial resistance to long term hospitalization.

Secondly, although there were more than twice as many females than males in the group studied, sex did not have any bearing upon the patients' ability to adjust. The majority of patients were young adults, who came from large family settings which were conducive to group adjustment, respect for advice and authority and emotional security.

Third, in addition, the patients had achieved some education above grade school level which fostered understanding of the nature and treatment of tuberculosis. Their educational attainment had also prepared them for employment of a skilled or professional level, which served to minimize undue concern over re-employment after discharge.

Fourth, most of the fifty patients were single or unattached and were living with family members at the time of hospitalization. These facts coupled with a degree of economic security for the majority, alleviated the conflict which often occurred in having to plan personally or for family

members while hospitalized.

Fifth, nearly all of the patients were diagnosed as having moderately or far advanced tuberculosis which required major surgery and an average hospital stay of from thirteen months to two years. However, the proximity of the hospital setting to friends and relatives, who gave these patients the psychological and social support needed, accentuated their ability to accept medical recommendations.

Sixth, the hospital program itself helped to promote acceptance of long term care. The adequacy of the hospital staff, the effective therapy program, the institutional features, such as social service, occupational therapy, vocational rehabilitation and recreational features were geared to meet the patient's needs and facilitated the treatment and recovery of these fifty patients. Moreover, the majority of patients formed favorable relationships with fellow-patients on whose friendship they relied as an additional resource in the adjustment process in a group setting.

Seventh, in spite of the many positive factors which characterized the patients studied, regardless of the available resources used by them and notwithstanding their desire to regain their health, most of them vascillated in their decision to remain hospitalized or to abscond. Those twelve in the group, who did leave against medical advice, returned and verbalized regret for their adverse actions. Thus, disturbing factors from an institutional, personal and social standpoint became so intense that even the most "cooperative" patient found it difficult to cope with the pressures that beset him.

Eighth, the criterion for satisfactory adjustment of the patients

studied was not based on length of hospital stay or apparent recovery. Rather, it involved whether or not the total experience had been beneficial in supplementing their emotional maturity or in alleviating their emotional insecurity, thereby preparing them psychologically and physically for discharge and adjustment to a post-hospital career.

Ninth, although emotional maturity attributed to the adjustment of the majority and some patients resumed treatment because of a mature prospective, the hospital was a haven for a few patients, who became "institutionalized," and the experience did not enhance their emotional growth. However, whatever the cause of their dependency reactions, it could not be considered as a sign of inadequacy, but as one of the "medico-sociologic" problems to be solved.

Tenth, tuberculosis was not a disease of the "poor and deprived" as was indicated by the majority of the patients in the study, but continued to affect those who were young; and finally, predisposition to group adjustment, emotional and economic security and a well-rounded hospital program did not prevent recalcitrance among the tuberculous. Approximately one-fifth of the group studied was recalcitrant which was minimal.

Generally, further study of tuberculous patients who have accepted and followed medical recommendations yet remained hospitalized until recovered, would facilitate a broader insight of their problems by medical social workers and others working with the tuberculous. Such understanding could help in the over-all movement for tuberculous control.

APPENDIX

SCHEDULE

I. SOCIAL DATA

Name _____ Date filled out _____ Age _____

Nationality _____ Place of Birth _____

Marital Status: S ____ M ____ D ____ Sep ____ Wid _____

Religion: Catholic _____ Non-Catholic _____

Education (grade completed): Grade ___ High ___ Col. ___ Other __

Housing at time of hospitalization _____

Employment prior to hospitalization _____

Present source of patient's and family's support _____

Status of patient's parents when living in the home:
- living together _____
- divorced _____
- separated _____
- one prt. dead or unknown _____
- both prts. dead or unknown _____

No. of siblings: none _____ No. of dependents? _____
- one _____
- two _____
- three or more _____

II. MEDICAL INFORMATION:

Has patient had previous long term hospitalization? _____

For tuberculosis? _____ How many? _____

Date of last sanatorium admission _____

Diagnosis upon admission: Minimal _____
- Moderately Advanced _____
- Far Advanced _____

Treatment recommended _____

Treatment received _____

INTERVIEW SCHEDULE

III. FACTORS AFFECTING ADJUSTMENT TO SANATORIUM REGIME

A. Environmental

1. What is your family's attitude toward your diagnosis?

_____

_____

2. Have you experienced worry over any family problems during hospitalization? ____ If so, what kind _____

_____

3. Has "home cure" been suggested since your hospitalization?

_____

B. Factors Related to Sanatorium

1. Is your condition discussed with you? _____
By whom? _____
What is your understanding of diagnosis and treatment?

_____

_____

2. Were you acquainted with hospital rules and regulations upon admission? _____

3. Do you get enough attention in the hospital? _____
From whom? _____

4. Do you like the food? most of the time ____ part time ___
hardly ever _____ never _____

5. Have you had to share a room with others? _____ If so, did you find it generally pleasant? _____ generally unpleasant _____ sometimes pleasant _____

6. Is the sanatorium near your family? _____

7. Do you have visitors? ____ too many ___ too few _____
enough _____

8. Do you receive mail? _____

9. Have you contacted social service for problems during hospitalization? ____ If so, were they helpful? _____

10. What do you do to pass the time? _____

_____

IV. Personality Factors

1. How did you feel when you learned of your diagnosis?

2. Was it hard for you to accept long term hospitalization? _____ If not, why? _____

3. Have you had surgery? ____ How did you feel about having it done? _____

4. How have you felt about your chances of getting well? fairly certain ___ hopeful ___ doubtful ___ fearful ____

5. How have you felt about going back to employment and leading a normal life? _____

6. Have there been times when you felt like leaving the sanatorium against medical advice? ____ If so, explain

7. If you didn't leave, what caused your change of mind?

8. Have you left the sanatorium against medical advice? If so, explain what prompted your actions _____

What caused you to return and resume treatment? _____

9. What has helped you most to adjust to hospital regime?

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